DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE PREFIX TAG (F 000) INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the investigation of Complaint IN00099124 - Complaint IN00099184 - Complaint IN00099	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249			(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
INTIAL COMMENTS (F 000) INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the investigation of Complaint IN00099184 -Corrected. Complaint IN00099274 -Corrected Survey dates: December 13,14,15, 2011 Facility number: 000153 Privider number: 155249 AlM number: 10026810 Survey team: Ann Armey, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicaid: 94 Other: 25 Total: 134 Sample: 7 Kindred Transitional Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 162. In regard to the PSR to the investigation of Complainted on the PSR to the investigation of Complainted Notice on the PSR to the investigation of Complaints Notice on the PSR to the investigation of Complaints Notice on the PSR to the investigation of Complaints Notice on the PSR to the investigation of Complaints Notice on the PSR to the investigation of Complaints Notice on the PSR to the PSR to the investigation of Complaints Notice on the PSR to the PSR to the PSR to the investigation of Complaints Notice on the PSR to			155249	B. WING				
PREFIX TAG					6006	6 BRANDY CHASE COVE		
This visit was for the Post Survey Revisit (PSR) to the investigation of Complaints IN00099184 and IN00099274 completed on 11/10/11. This visit was in conjunction with the investigation of Complaint IN00100023. Complaint IN00099184-Corrected. Complaint IN00099274-Corrected Survey dates: December 13,14,15, 2011 Facility number: 000153 Provider number: 155249 AlM number: 100266910 Survey team: Ann Armey, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicaire: 15 Medicaid: 94 Other: 25 Total: 134 Sample: 7 Kindred Transitional Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the investigation of Complaints IN00099184 and	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	REFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		SHOULD BE COMPLETIC	
Census payor type: Medicare: 15 Medicaid: 94 Other: 25 Total: 134 Sample: 7 Kindred Transitional Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the investigation of Complaints IN00099184 and	{F 000}	This visit was for the to the investigation of and IN00099274 condition of Complaint IN00100 Complaint IN000991 Complaint IN000992 Survey dates: December Facility number: 0000 Provider number: 15 AIM number: 100266 Survey team: Ann Armey, RN Census bed type: SNF/NF: 134	e Post Survey Revisit (PSR) of Complaints IN00099184 onpleted on 11/10/11. unction with the investigation 0023. 84-Corrected. 74-Corrected onber 13,14,15, 2011	{F (000}	DEFICIENC!)		
L L L L L L L L L L L L L L L L L L L		Census payor type: Medicare: 15 Medicaid: 94 Other: 25 Total: 134 Sample: 7 Kindred Transitional compliance with 42 0 410 IAC 16.2 in rega investigation of Com IN00099274.	CFR Part 483, Subpart B and rd to the PSR to the plaints IN00099184 and					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155249	B. WING			R-C 12/15/2011	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHAB-FORT WAYNE		6006	T ADDRESS, CITY, STATE, ZIP CODE BRANDY CHASE COVE ST WAYNE, IN 46815	1271	3/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION	
{F 000}	Continued From pag Quality review compl Cathy Emswiller RN		{F 0	00}			